AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT- MINOR

I. MEDICAL INFORMATION (please type or print legibly)

a. Name of Minor _____
(last, first, middle)

b. Name of Parent/Guardian _____
(last, first, middle)

Address _____
(street or P.O. box, city, state, zip code)

Telephone Number: Day (___) _____ Night (___) _____

c. Minor's Physician _____

Address _____
(street or P.O. box, city, state, zip code)

Telephone Number: Office (___) _____ Emergency (___) _____

d. Minor's Dentist _____

Address _____
(street or P.O. box, city, state, zip code)

Telephone Number: Office (___) _____ Emergency (___) _____

e. Health Insurance Company Name _____

Policy Number _____ Telephone (___) _____

f. Minor's Allergies _____

g. Minor's Current Medications _____

h. Minor's Special Health Needs _____

II. EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned parent or legal guardian of _____
(name of minor)

do hereby authorize The University of Texas at Austin and its designated representatives to consent, on my behalf, to any medical/hospital care or treatment to be rendered to _____ upon the advice of any licensed
(name of minor)

physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

The effective date of this authorization is _____.

_____ Date: _____, ___.
(Signature of Parent or Guardian)

(for persons less than eighteen years of age) revised 2-96